

Division of Health Care Facilities

| | | | | | |
|---|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3308 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/22/2011 |
| NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF EAST RIDGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1500 FINCHER AVENUE EAST RIDGE, TN 37412 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE |
| N 000 | Initial Comments Complaint investigation #28931 was completed at Life Care Center of East Ridge on December 22, 2011. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | | |

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

FL0M11

If continuation sheet 1 of 1